

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/30/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/10/2010
NAME OF PROVIDER OR SUPPLIER  NIM HENSON GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	<b><u>THIS PLAN OF CORRECTION CONSTITUTES MY WRITTEN ALLEGATION OF COMPLIANCE FOR THE DEFICIENCIES CITED. HOWEVER, SUBMISSION OF THE PLAN OF CORRECTION IS NOT AN ADMISSION THAT A DEFICIENCY EXISTS OR THAT ONE WAS CITED CORRECTLY. THIS PLAN OF CORRECTION IS SUBMITTED TO MEET REQUIREMENTS ESTABLISHED BY STATE AND FEDERAL LAW.</u></b>	
F 221 SS=D	<p>A standard health survey was conducted on November 8-10, 2010. Deficiencies were cited with the highest scope and severity at "E" level.</p> <p>463.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one (1) of eighteen (18) sampled residents (resident #9) was free from physical restraints. Resident #9 was observed to utilize a lap buddy while out of bed in a wheelchair; however, there was no evidence the device was utilized to treat a medical symptom, no comprehensive care plan had been developed for the restraint, and no assessment had been conducted prior to use of the lap buddy for this resident. In addition, there was no evidence the facility had informed the resident's responsible party of the risks/benefits related to the use of the lap buddy for resident #9.</p> <p>The findings include:</p> <p>Observation on November 9, 2010, at 3:30 p.m., revealed resident #9 in the resident's room sitting in a wheelchair with a lap buddy on. Resident #9 stated he/she was unable to remove the lap buddy, stated he/she wanted to go back to bed, did not like sitting up in a chair.</p>	F 221	<p><b><u>THIS PLAN OF CORRECTION CONSTITUTES MY WRITTEN ALLEGATION OF COMPLIANCE FOR THE DEFICIENCIES CITED. HOWEVER, SUBMISSION OF THE PLAN OF CORRECTION IS NOT AN ADMISSION THAT A DEFICIENCY EXISTS OR THAT ONE WAS CITED CORRECTLY. THIS PLAN OF CORRECTION IS SUBMITTED TO MEET REQUIREMENTS ESTABLISHED BY STATE AND FEDERAL LAW.</u></b></p> <p>F221,</p> <p><i>On 11/10/10 resident #9 was updated, on signed permission form, care plans, assessments, physicians orders, stating the medical symptom requiring restraint.</i></p> <p><i>All residents were assessed for possible restraint usage. Only one other resident was identified as using a restraint. This resident was re-evaluated, Care Plan updated, permission form checked, and M.D. order reviewed with the MDS schedule on 11/12/10.</i></p> <p><i>The restraint policy has been revised and updated as well as the restraint committee to insure this deficient practice will not re-occur. All nursing staff will be inserviced on 12/13 and 12/15/10 of the revised policy.</i></p> <p><i>The restraint committee will meet monthly with QA. The D.O.N., Supervisor, or their designee will complete a quarterly audit of all patients with restraints.</i></p> <p>Completion Date: 12/15/10</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Phillip Fitts*

TITLE

*Administrator*

(X6) DATE

12-9-10

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	<p>Continued From page 1</p> <p>Record review revealed resident #9 was admitted to the facility on January 21, 2010, with diagnoses of Diabetes Mellitus, Coronary Artery Disease, Aortic Sclerosis, Hypertension, and worsening Senile Dementia. Resident #9's Minimum Data Set (MDS) dated July 27, 2010, revealed the resident was moderately impaired in decision-making. The MDS also revealed the resident required assistance with transfers and mobility.</p> <p>Further record review of incident reports revealed documentation that resident #9 was found on March 5, 2010 and March 8, 2010, sitting at the bedside after attempting to get out of bed. The record revealed a physician's order was obtained on March 8, 2010, for a lap buddy to be used when resident #9 was up in a wheelchair. However, there was no evidence of a medical symptom to support the use of the lap buddy. There was no evidence the facility had conducted an assessment prior to the use of the lap buddy and periodically throughout the resident's stay to determine warranting the continual use of the lap buddy. In addition there was no evidence the facility had informed the resident's responsible party (R/P) of the risks/benefits associated with using a restraint device.</p> <p>Interview on November 8, 2010, at 1:24 p.m., during initial tour with Licensed Practical Nurse (LPN) #1 revealed resident #9 required the use of a lap buddy when out of bed in a wheelchair. LPN #1 stated the lap buddy was required due to a history of falls.</p> <p>Interview on November 10, 2010, at 10:00 a.m., with LPN #2 revealed resident #9 required the use of the lap buddy when up in a wheelchair.</p>	F 221		

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F 221	<p>Continued From page 2</p> <p>Further interview revealed the lap buddy was released when the resident was at the nurses' station under direct observation. Interview further revealed the resident was unsteady on his/her feet and forgetful at times and the resident could remove the lap buddy at times but not on command, thus making the lap buddy a restraint. LPN #2 stated he/she believed the lap buddy was required to prevent falls, and to prevent the resident from getting up without assistance.</p> <p>Interview with the MDS Coordinator on November 10, 2010, at 10:34 a.m., revealed resident #9 was coded on the MDS dated October 27, 2010, as requiring a restraint. However, the MDS Coordinator stated no care plan or Care Area Assessment was developed for the restraint use.</p> <p>Interview with the Director of Nursing on November 10, 2010, at 11:04 a.m., revealed the nursing staff who obtained the order for the restraint was responsible along with the physician for assessing risks/benefits of restraint use and obtaining consent from the R/P showing risks/benefits were discussed. Further interview revealed the MDS Coordinator was responsible for quarterly monitoring of the restraint to ensure the use of the restraint was still needed.</p> <p>Interview with LPN #3 on November 10, 2010, at 11:30 a.m., revealed no quarterly restraint assessment had been completed on resident #9 regarding the use of the restraint and that it continued to be accurate to the resident's current condition.</p> <p>A review of the facility policy/procedure related to restraints, not dated, revealed residents would be free from physical restraints imposed for</p>	F 221		

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F 221	Continued From page 3 purposes of discipline or convenience, and not required to treat the resident's medical condition. According to the policy, restraints may have been used for emergency care for brief periods to permit medical treatment, and if a resident's unanticipated violent or aggressive behavior placed him/her or others in imminent danger the resident may be restrained as a last resort to protect the safety of the resident or others. The restraint must not extend past the immediate episode. Further review of the policy revealed a comprehensive assessment was to be made at the time of admission and periodically throughout the resident's stay to determine the resident's medical condition/symptoms warranting the use of restraints. The resident or R/P was to have been provided detailed information related to the risks/benefits of restraint use and a signed acknowledgment was to be maintained in the resident's medical record. The needs/goals related to the resident's identified medical condition warranting the use of restraints, as well as use of appropriate interventions to meet those needs, were to be identified in the resident's individualized care plan, according to the policy. In addition, the policy stated the process to reduce the use of restraints should be systematic and gradual, and a physician's order was to be obtained to include specific medical symptoms requiring the restraint.	F 221		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248	F248,  <i>Resident #8 Care Plan was updated to include the in room activity request from family which states that resident likes to have it on a music channel and TV is to be left on all day. TV is to be turned on by Activity Staff, or any other staff designated by Activity Director. Update was done on 11/9/10.</i>	

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F 248	Continued From page 4  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide one (1) of eighteen (18) sampled residents (resident #8) an ongoing program of activities designed to meet the mental and psychosocial well-being of each resident.  The findings include:  Review of the medical record revealed resident #8 was admitted to the facility on April 24, 1981, with diagnoses that included Chronic Brain Disease, Agitation, Cerebral Palsy, and Mental Retardation. Review of the comprehensive assessment for resident #8, dated as completed on October 7, 2010, revealed the resident had been assessed to be severely cognitively impaired and to require extensive assistance from staff for all activities of daily living. A review of the Care Area Assessment for this assessment revealed resident #8 enjoyed listening to music on his/her television.  A review of the Care Plan for resident #8 revealed staff would have the resident up and ready for Jitterbugs on Tuesdays, Wednesdays, and Thursdays. The Care Plan further revealed if the resident was not at Jitterbugs, staff would provide one-to-one sensory stimulation and socialization, and would encourage family involvement. The Care Plan did not address the resident's enjoyment of music or television. However, a review of the activity notes for resident #8 dated October 7, 2010, revealed the staff would have the television on in the resident's room daily.	F 248	<i>Jitterbug (Low Cognitive) has been changed to 5 days a week to increase stimulation of patients with cognitive impairment. An audit was done on cognitively impaired residents and a revised Jitterbug List (Low Cognitive) was done on 11/17/10.  Inservice on 12/13 &amp; 12/15/10 will be given to floor staff. We will go over resident # 8 to make sure that it is understood by all to keep TV on and on music channel. We will also inservice the importance of Low Cognitive residents participation in activities. Activity Department will monitor in room intervention (turning on TV) during Rise and Shine which begins at 8:15 daily, along with other floor staff with daily care. Activities will do a random check 2 times a month to check and see if TV is on and on right channel. A log on daily participation is kept by activities. Q.A. committee will be informed of any problem.  Completion Date:</i>	12/15/10
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F 248	Continued From page 5 Observations of resident #8 on November 8, 2010, from 2:30 p.m. to 5:10 p.m., and on November 9, 2010, from 9:10 a.m. to 3:00 p.m., revealed the resident was in bed in the resident's room with his/her eyes closed. The television was observed to be off during the observations.  A sign was observed hanging on resident #8's closet door stating, "Per family request: do not turn the television off during the day. Please keep the station on music as this makes [resident #8] happy." The sign was dated March 16, 2010, and signed by Licensed Practical Nurse #3 who was a family member of resident #8.  An interview conducted on November 9, 2010, at 2:00 p.m., with the Minimum Data Set (MDS) Coordinator for the facility revealed the Activities Director was responsible for completing the Activity Care Plan for the residents of the facility. The MDS Coordinator further stated he/she was unaware of an intervention to address keeping the television on for resident #8.  An interview conducted on November 9, 2010, at 3:05 p.m., with the facility's Activities Director (AD) revealed the AD was not aware the sign from the resident's family had been hanging on the closet door. The AD stated he/she was aware resident #8 enjoyed the television being on and had placed the fact in the Activity Notes, but had failed to add an intervention addressing keeping the television on for resident #8 in the resident's Care Plan.	F 248			
F 279 ES=D	483.20(d). 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's	F 279	F279 <i>The Care Plans for the affected residents (#1 and #3) have been revised to reflect that the current deficiencies have been addressed.</i>		

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F 279	<p>Continued From page 6 comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to develop a comprehensive care plan for two (2) of eighteen (18) sampled residents. Residents #1 and #3 required the use of an anticoagulant/blood thinner; however, a care plan was not developed to address the anticoagulants and necessary precautions. Additionally, resident #1 had a peripherally inserted central catheter (PICC) line and the facility failed to develop a care plan related to the care/precautions and possible complications related to a central intravenous line.</p> <p>The findings include:</p>	F 279	<p>An audit has been completed per nursing staff to manage residents on anticoagulant therapy. Care Plans were updated for residents identified as result of audit.</p> <p>A Care Plan checklist was put into effect as of 11/10/10 and is done prior to completion of each Care Plan made. The checklist will be kept in the MDS office with the resident's file. Also, the nursing staff is now required to provide a copy of all new orders to MDS to facilitate in Care Plan updates.</p> <p>All residents will receive quarterly reviews to ensure all needs are being met and Care Plans are updated to show current status.</p> <p>Completion Date:</p>	12/15/10

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F 279	<p>Continued From page 7</p> <p>1. Review of the medical record revealed resident #1 was admitted on October 8, 2010, with diagnoses of Spina Bifida, Infected Stage IV Decubitus Ulcer, Chronic Pain, and Anxiety Disorder. Review of the Admission Minimum Data Set (MDS) dated October 22, 2010, revealed the facility assessed resident #1 to be alert and oriented and independent in daily decision-making.</p> <p>Review of the admission physician's orders dated October 8, 2010, revealed resident #1 required Warfarin (an anticoagulant/blood thinner) 4 milligrams (mg) once daily. Further review revealed resident #1 was to receive antibiotics Daptomycin 500 mg and Ivanz 1 gram intravenously (IV), once daily for three weeks.</p> <p>Review of the Comprehensive Care Plan dated October 21, 2010, revealed the facility failed to develop a comprehensive care plan that included measurable objectives, interventions, and timetables to meet resident #1's needs related to the anticoagulant/blood thinner use and the PICC line.</p> <p>Interview on November 9, 2010, at 11:35 a.m., with the MDS Coordinator revealed the MDS Coordinator was responsible for the development of the Comprehensive Care Plan. The MDS Coordinator stated the Comprehensive Care Plan was developed from the assessment information, areas triggered from the comprehensive assessment, medications, and the resident's diagnoses. The MDS Coordinator revealed he/she had failed to develop a care plan to address the PICC line and anticoagulant use and had just overlooked the areas.</p>	F 279		

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F 279	Continued From page 8 Review of the facility's Comprehensive Care Plan Policy, not dated, revealed the MDS nurse was responsible for the development of the Comprehensive Care Plans.  2. A review of the medical record for resident #3 revealed the resident had been admitted to the facility on December 22, 2001, with diagnoses to include Cerebral Vascular Accident, Coronary Artery Disease, Cerebral Aneurysm, and Renal Artery Stenosis. The medical record further revealed a physician's order dated October 1, 2010; for Heparin-(blood-thinner) 5,000-units to be administered subcutaneously twice daily.  A review of the Comprehensive Care Plan for resident #3 revealed no evidence the Care Plan addressed the resident's Heparin therapy.  An interview conducted on November 9, 2010, at 2:00 p.m., with the Minimum Data Set (MDS) Coordinator for the facility revealed he/she would have expected to see a Care Plan addressing the use of Heparin for resident #3. The MDS Coordinator further stated it was just an oversight and was unsure why it was not placed in the Care Plan for the resident.	F 279			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to meet professional standards of service for one (1)	F 281	F281  <i>On 11/10/10 the floor nurse immediately placed a fall mat for Resident #12.</i>  <i>On 11/10/10 the D.O.N. and Restorative Nurse completed an audit of all safety interventions and no other residents were found to be affected by the deficient practice.</i>		

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F 281	<p>Continued From page 9</p> <p>of eighteen (18) sampled residents. The facility failed to follow the physician's order for the use of fall mats at resident #12's bedside to prevent injury due to risk of falls.</p> <p>The findings include:</p> <p>Resident #12 was admitted to the facility on August 6, 2007, with medical diagnoses that included Alzheimer's Dementia, Schizophrenia, Hypocalcemia, and Hyperparathyroidism. Resident #12 had a physician's order for fall mats.</p> <p>Record review of a Fall Risk Assessment dated September 26, 2010, for resident #12 revealed a total score of 18, which represents high risk for falls. Additional record review of the physician's order dated October 1, 2010, revealed resident #12 was ordered mats at bedside for safety.</p> <p>A review of resident #12's care plan revealed a goal for the resident to remain free of falls and an intervention for fall mats at the bedside at all times while the resident was in bed.</p> <p>Observations conducted on November 9, 2010, at 3:35 p.m. and on November 10, 2010, at 10:15 a.m., revealed resident #12 resting in bed without visible fall mats at his/her bedside.</p> <p>An interview conducted on November 10, 2010, at 2:00 p.m., with Certified Nurse Assistant (CNA) #3 revealed resident #12 had an order for fall mats at the bedside to prevent injury because the resident attempted to self-transfer from the bed. CNA #3 stated he/she was responsible for making sure fall mats were in place when resident #12 was in bed. CNA #3 further stated</p>	F 281	<p><i>The Restorative Nurse will update the list of all safety interventions and check for compliance every month. She will then forward the list on to the D.O.N./Supervisor as well as the floor staff. All nursing staff will be inserviced on 12/13 &amp; 12/15/10 of the need to monitor all safety interventions on a daily basis.</i></p> <p><i>The D.O.N./Supervisor or their designee will complete a quarterly review of all safety interventions and check for compliance. Q.A. committee will be notified of any Continued problems.</i></p> <p><i>Completion Date:</i></p>	12/15/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/10/2010
NAME OF PROVIDER OR SUPPLIER  NIM HENSON GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339	
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F 281	Continued From page 10 one fall mat was removed from resident #12's room that morning because the mat was torn, however, the mat was not replaced. CNA #3 was unable to recall why the other fall mat was not in place.  An interview conducted on November 10, 2010, at 10:20 a.m., with the Team II Charge Nurse (CN) revealed resident #12 had physician's orders for fall mats at the bedside because the resident was at risk for falls. The CN stated he/she was responsible for monitoring to ensure resident #12 had fall mats at the bedside when in bed.	F 281		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as possible. Observation during environmental tour revealed the facility failed to ensure a disinfectant spray, disposable razors, medicated shampoos, shaving cream, and syringes were secured/locked and not accessible to residents.  The findings include:	F 323	<b>F323</b>  <i>No individual resident was identified as being affected by the exposure to unsecured medical supplies. Disposal razors, shaving cream, disinfectant spray, clotrimazole/betamethasone dipropionate cream, and shampoo were immediately removed or secured. (Hooks placed on cabinets in showers) Floor staff was verbally counseled on the potential danger of this practice. Unsecured insulin syringes were immediately removed and secured. Nurse on duty was verbally counseled on the potential danger of this practice.</i>	

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F 323	<p>Continued From page 11</p> <p>Observation during environmental tour on November 8, 2010, at 5:25 p.m., revealed three unsecured disposable razors on a shelf in the shower room located on the Team II Unit.</p> <p>Further observation of the shower room located on the Team I Unit revealed an unsecured/unlocked wall cabinet that contained the following: nine disposable razors, an unopened box of 50 disposable razors, one unopened package of ten disposable razors, one partially used can of Gillette Foamy Shaving Cream, a partially used container of Premier Microfoam Disinfectant Spray, a 4-ounce bottle of Selenium Sulfate Shampoo dispensed from the pharmacy that contained a resident's name and instructions for use, and a 45-gram tube of Clotrimazole/Betamethasone Dipropionate Cream.</p> <p>Observation on November 9, 2010, at 9:30 a.m., of the women's shower room located on the Team III Unit revealed three disposable razors and a partially used bottle of Selenium Sulfate Shampoo dispensed from the pharmacy that contained a resident's name and instructions for use. Observation of the men's shower room located on the Team III unit revealed an unsecured/unlocked wall cabinet that contained three disposable razors and one partially used can of Gillette shave cream.</p> <p>Further observation on November 9, 2010, at 10:00 a.m., revealed a medication cart unattended in the hallway near the Team III nurses' station that contained unsecured unopened insulin syringes that were accessible to residents, staff, and the public. Further</p>	F 323	<p><i>A walking check of all medication carts and shower rooms done by the D.O.N. did not reveal any carts or shower rooms with unsecured items.</i></p> <p><i>Staff will be inserviced on 12/13 &amp; 12/15/10 as to the potential danger of having unsecured items in showers and on medication carts. Material Safety Data Sheets and proper storage will also be discussed.</i></p> <p><i>The D.O.N./Floor Supervisor/Administrator will monitor shower rooms and med cart for compliance during daily rounds. Medication carts will be monitored monthly by pharmacy. The Q.A. committee will be asked for input on any continued problem.</i></p> <p><i>Completion Date: 12/13 &amp; 12/15/10</i></p>

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F 323	Continued From page 12 observation on November 10, 2010, at 9:30 a.m., revealed the medication cart remained in the hallway unattended with the insulin syringes accessible to residents, staff, and the public.  Review of the facility's Census and Conditions revealed 44 residents had a diagnosis of Dementia. Review of the facility's list of residents that were assessed to be at risk for wandering/elopement revealed eight were at risk.  Review of the Material Safety Data Sheet (MSDS) for the Premier Foam Disinfectant revealed misuse of the disinfectant could be harmful or fatal. Further review of the MSDS information for Selenium Sulfate Shampoo revealed the product could be harmful if ingested.  Interview on November 10, 2010, at 8:55 a.m., with the Director of Nursing (DON) revealed the nurses were responsible for checking the shower rooms to ensure razors and harmful items were not accessible to residents. The DON stated razors were stored in the supply room and medicated shampoos were stored in the treatment carts. The DON stated the items observed unsecured/unlocked could be harmful to residents and should never be accessible to residents.  Review of the facility policy related to storage of medications and syringes dated May 10, 2010, revealed all medications and biologicals, including treatment items, were required to be securely stored in a locked cabinet/cart or locked medication room that was not accessible by residents and visitors.	F 323		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS	F 411		

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F 411	<p>Continued From page 13</p> <p>The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to promptly refer one (1) of eighteen (18) sampled residents with a lost denture to a dentist. Resident #11 had lost the upper denture, approximately in June 2010, however, no dental appointment had been made.</p> <p>The findings include:</p> <p>Review of resident #11's medical record revealed the resident was admitted on August 18, 2008. Resident #11 had diagnoses of Depression, Dementia, Chronic Obstructive Pulmonary Disease, and Anxiety. Review of the Minimum Data Set (MDS) dated October 6, 2010, revealed the resident was cognitively intact.</p> <p>Interview on November 8, 2010, at 6:00 p.m., in the facility dining room with resident #11 revealed the resident's upper denture had been lost.</p>	F 411	<p>F411</p> <p><i>On November 11, 2010, an appointment for Resident #11 was scheduled at the Vicco Dental Clinic for November 19<sup>th</sup> at 10:00am. Resident had an appointment on December 1<sup>st</sup> for fitting. Appointment is scheduled for December 10<sup>th</sup> at 10:45 a.m.</i></p> <p><i>Any resident with dentures would be at risk to break or lose their dentures. Residents are assessed at admission by the admitting nurse for dental needs identifying if the resident has dentures. (see attachment) No other residents have dentures missing. Dr. Rodney Griffith, DMD, conducts annual dental checkups for all residents.</i></p> <p><i>A copy of dental record forms will be given to Social Worker for all residents who have dentures.</i></p> <p><i>Denture Protocol (Attached) developed and all staff will be inserviced on 12/13 &amp; 12/15/10.</i></p> <p><i>Social Worker will address any issues regarding dentures at the weekly Department Head meetings. The Denture Protocol will serve as a daily means of monitoring. QA will address any concerns.</i></p> <p>Completion Date:</p>	12/15/10	

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F 411	Continued From page 14 Resident #11 stated that at night the denture was taken out to be cleaned, and then placed in a cup for the night. Resident #11 further stated one morning the cup that contained the resident's upper denture was missing. Resident #11 stated the incident took place a few months ago, however, was not certain of the exact month. Interview further revealed the resident had informed staff that the denture was missing. According to the resident it was hard to eat some meals due to the loss of the upper denture and he/she would like to have the denture replaced.	F 411		
F 425 SS=D	Interview on November 10, 2010, at 11:23 a.m., with the Social Services Director (SSD) revealed the SSD was aware resident #11's upper denture was missing. The SSD stated that staff had looked for the denture and was unable to find the denture.  Interview on November 10, 2010, at 1:30 p.m., revealed the SSD had "not thought about [resident #11's] teeth lately," and no further effort had been made to locate or replace the missing denture. Interview further revealed the denture was lost approximately in June 2010, and the SSD had not obtained a dental appointment since the loss of the denture.  483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	F425,  <i>The expired medication for resident #5 was removed and M.D. and Pharmacy were notified.</i>  <i>The medication cart was then audited that day for any further expired medications and none were found. The Pharmacy also completed a monthly audit of all medication carts on 11/16/10.</i>	

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F 425	<p>Continued From page 15</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to label, date, and store all drugs and biologicals in accordance with currently accepted professional principles. The facility had thirteen (13) Thera Tablets with an expiration date of October 31, 2010. The expired Thera Tablets were administered to resident #18 every day from November 1, 2010 through November 9, 2010, and were available for future use.</p> <p>The findings include:</p> <p>An observation of the Team II medication cart conducted on November 10, 2010, at 1:20 p.m., revealed 13 Thera Tablets with an expiration date of October 31, 2010, available for use for resident #18.</p> <p>An interview conducted on November 10, 2010, at 1:20 p.m., with Licensed Practical Nurse (LPN) #5 revealed it was his/her responsibility to check the expiration date of all residents' medications</p>	F 425	<p><i>To ensure that this deficit practice does not re-occur the night shift nurse will complete a bi-monthly cart audit. The medication carts will be checked for expired medication and any found will be removed. M.D. and Pharmacy will then be notified. All nursing staff will be inserviced on 12/13 &amp; 12/15/10 as to insure compliance.</i></p> <p><i>To ensure that the solutions are sustained, the Pharmacy will continue their monthly audits, and night shift nurses will continue bi-monthly audits. Q.A. committee will address any problems.</i></p> <p>Completion Date:</p>	12/15/10

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F 425	Continued From page 16 and remove all expired medication from the medication cart and return them to the pharmacy. LPN #5 was unaware the 13 Thera Tablets had expired. The LPN further stated resident #18 had received the expired Thera Tablet daily since November 1, 2010.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of	F 431	F431  <i>All non-labeled bottles were removed and re-ordered on 11/10/11.</i>  <i>All medication carts were audited that day for any further non-labeled bottles and none other were found. The pharmacy also completed a monthly cart audit on 11/16/10.</i>  <i>To ensure that this deficit practice does not re-occur, the night shift nurse will complete a bi-monthly cart audit. The medication bottles will be checked for opening date and any found with no opened dates will be removed. Pharmacy will then be notified. All nursing staff will be inserviced on 12/13 &amp; 12/15/10 as to ensure compliance.</i>	

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F 431	<p>Continued From page 17</p> <p>controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to label, date, and store all drugs and biologicals in accordance with currently accepted professional principles. One (1) vial of Hep-lock solution and twelve (12) bottles of liquid medication had been opened and available for use; however, the medications were not dated to indicate the date the bottles were opened.</p> <p>The findings include:</p> <p>Observation on November 10, 2010, at 1:15 p.m., of the facility's medication rooms/carts revealed a 30-milliliter (ml) vial of Hep-lock solution had been opened and remained available for use. Further observation revealed the vial failed to indicate the date the vial was opened.</p> <p>Continued observation revealed three bottles of liquid Megace, three bottles of liquid DeChlor DM, one bottle of liquid Milk of Magnesia, one bottle of liquid Vitamin C, one bottle of liquid Thera Plus, one bottle of liquid Ferrous Sulfate, one bottle of liquid Enulose, and one bottle of liquid Nystatin had been opened but were not dated to indicate when the bottles were opened.</p>	F 431	<p><i>To ensure that the solutions are sustained, the pharmacy will continue their monthly audits. Q.A. committee will be consulted on any problems.</i></p> <p><b>Completion Date:</b></p>	12/15/10	

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F 431	Continued From page 18  Interview on November 10, 2010, at 1:25 p.m., with LPN #4 revealed all liquids and vials were required to be dated when opened.  Interview on November 10, 2010, at 2:00 p.m., with the DON revealed staff was required to date all liquids and multi-dose vials when opened.  The facility failed to provide a policy regarding the requirement of dating liquid medications; however, a policy was provided that revealed all multiple-dose vials for injection were to be dated when opened and discarded after 28 days.	F 431		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain accessible/fully functional call light systems in residents' bathrooms and in the shower rooms.  The findings include:  Observations during the environmental tour on November 8-9, 2010, revealed in shower room 2, on the Team II Unit, the emergency activation pull cord protruded from the wall approximately six inches. Observation on the Team III Unit revealed in the women's shower room the emergency activation pull cord protruded from the	F 463	<i>F463</i>  <i>No resident was identified as being affected by short cords on call lights. Cords were replaced in shower room 2, Team II unit, women's shower, Team III unit, men's shower, room 106 bathroom, and room 145 bathroom on 11/10/10.</i>  <i>Any resident could be affected if call lights in any area were too short for easy access. A visual inspection on 11/10/10 by the maintenance and housekeeping supervisors did not reveal the need for additional cords.</i>  <i>Staff will be inserviced on the necessity of immediate reporting of any problem with call lights on 12/13 &amp; 12/15/10. On 12/3/10, maintenance supervisor was also inserviced on prompt repairs. Staff will continue to record regular repairs on list available in each nurses' station.</i>  <i>Maintenance will be notified of any immediate need for repairs.</i>	

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F 463	Continued From page 19 wall approximately six inches, and in the men's shower room the emergency activation pull cord extended approximately three inches from the activation switch.  Further observation revealed in resident room 106 the bathroom emergency call bell did not have a pull cord and in resident room 145 the bathroom emergency activation pull cord only extended out from the activation switch approximately three inches.  Interview on November 10, 2010, at 10:20 a.m., with the Maintenance Supervisor (MS) revealed the MS checks the call bells on a weekly basis. The MS stated a clipboard was kept at each nurses' station for staff to document any items in need of repair. The MS stated he/she was not aware of the damaged/missing call bell pull cords.	F 463	<i>Housekeeping supervisor will monitor rooms weekly for needed repairs. The administrator/designee will do daily observations for needed repairs plus complete a thorough quarterly inspection. QA committee will be asked for solutions to any ongoing problem.</i>  <i>Date Corrected: 12/13 &amp; 12/15/10</i>	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Door knobs were loose in four (4) resident rooms, the commode basins were stained in five (5) resident bathrooms, a shower curtain was stained, a commode seat was chipped, and holes were observed in two (2) resident rooms.	F 465	<i>No resident was identified as being affected by the following environmental issues. The door knobs to resident bathroom doors 111 and 144 and entry doors to resident rooms 155 and 158 were repaired or replaced on 12/7/10. Commodes in resident rooms 102, 110, 143, 144, and 151 will be replaced by 12/22/10. Holes in resident rooms 145 and 106 were repaired on 12/03/10. Stain was removed above 145 bathroom baseboard on 12/06/10. Shower curtain in Team II shower #2 was replaced on 12/8/10. The light above sink in resident room 103 was repaired on 11/10/10. Commode seat was replaced in resident room 106 on 12/3/10. Wallpaper border and wall was repaired near room 108 on 12/8/10. Faucets repaired in Team III women's shower on 12/3/10. Room 111 sink faucet will be replaced by 12/22/10. Tissue paper dispenser was replaced in resident room 116 on 11/11/10. Nail removed from resident room 120 wall on 11/10/10.</i>	

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F 465	Continued From page 20  The findings include:  During the environmental tour of the facility on November 9-10, 2010, the following items were observed to be in need of repair:  -Door knobs were loose on the bathroom doors in resident rooms 111 and 144 and the entry door to resident rooms 155 and 158. -A blackish stain was observed on the commode basin of resident rooms 102, 110, 143, 144, and 151. -Holes were observed in the wall above the head of the bed in resident room 146 and beside the air conditioner in resident room 106. -A brownish stain was observed above the baseboard in the bathroom of resident room 145. -The navy shower curtain in shower 2 on the Team II Unit was stained with a white unknown substance. -The light above the sink in resident room 103 would not turn on. -The commode seat in the bathroom of resident room 106 was chipped/scratched. -The wall paper border was torn, exposing cracked drywall near the entry door of resident room 108. -The sink faucet in the Team III Unit women's shower room was loose. -A brownish stain was observed on the sink faucet in resident room 111. -The tissue paper dispenser bar was missing in resident bathroom 116. -A nail was protruding from the wall at the entrance to the bathroom in resident room 120.  Interview on November 10, 2010, at 10:20 a.m., with the Maintenance Supervisor (MS) revealed a	F 465	<i>Any resident could be affected if the environment is not kept safe/functional/sanitary/comfortable. A visual building inspection was done by housekeeping and maintenance on 12/3/10 and the need for additional repairs was not identified. A complete inspection for any needed repairs will be done by the administrator/designee by 12/22/10.</i>  <i>Staff will be inserviced on 12/13 &amp; 12/15/10 on the importance of and procedure for reporting needed repairs. Routine maintenance needs will be recorded on repair list in nurses stations and addressed daily by maintenance worker. Maintenance supervisor was inserviced on 12/3/10 about timely repairs.</i>  <i>Housekeeping and maintenance supervisor will monitor the building daily for needed repairs. Administrator will observe daily and do a complete quarterly inspection of the building. Any problems will be presented to the QA committee for solutions.</i>  Completion Date: _____	12/22/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/30/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/10/2010
NAME OF PROVIDER OR SUPPLIER  NIM HENSON GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 21 clipboard was kept at each nurses' station for staff to document any items in need of repair. The MS stated the MS made rounds twice a day to check the clipboard for items in need of repair. The MS was not aware of identified areas in need of repair.	F 465		
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to obtain laboratory services to meet the needs of one (1) of eighteen (18) sampled residents. Resident #3 had a physician's order for a Fasting Lipid Profile to be obtained. However, the facility failed to obtain the laboratory test.  The findings include:  A review of the medical record for resident #3 revealed the resident had been admitted to the facility on December 22, 2010, with the following diagnoses: Coronary Artery Disease, Cerebral Vascular Accident, Cerebral Aneurysm, and Hypertension. The medical record further revealed a physician's order dated September 15, 2010, for a Fasting Lipid Profile to be drawn and repeated every three months. However, there was no evidence the laboratory test had been conducted.	F 502	F502,  On 11/10/10 a physician order for Resident #3 was obtained and a FLPD was drawn and the results reported to the physician.  A lab audit was completed of all patients of resident #3's M.D. and no other missing Laboratory tests were found.  The laboratory policy was updated to include instructions to immediately place any laboratory orders on the lab book as well as the lab card for the date ordered. Staff will be inserviced 11/13 & 11/15/10.  The D.O.N./Supervisor or their designee will complete a 10% of the census, lab audit each month on 10% of census . She/he will then log the availability or non-availability of the specimen. For any absent labs they will notify the ARH Lab and obtain duplicate copies to be reported to the M.D. If at any time a lab has not been obtained it will immediately be drawn and M.D. notified. Any continued issues will be reviewed by Q.A. committee.  Completion Date:	12/15/10

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NAME OF PROVIDER OR SUPPLIER  NIM HENSON GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	<p>Continued From page 22</p> <p>An interview conducted on November 9, 2010, at 1:35 p.m., with the Nursing Supervisor (NS) revealed after the nurse received a physician's order for a laboratory specimen the order was placed on an index card. The NS or her designee was then responsible for placing all laboratory orders from the index cards onto the laboratory calendar for the laboratory specimen to be drawn. The NS further stated he/she had failed to add the Fasting Lipid Profile to the calendar for resident #3. The NS further stated the facility had an audit nurse who worked two days every month and monitored all charts for missing laboratory orders. The NS stated the audit nurse had not been aware of any missing laboratory specimens for resident #3.</p> <p>A review of the laboratory policy titled NHGC Laboratory Policy, with no date, revealed the policy did not address a timeframe for obtaining routine ordered labs. The policy stated physician's orders shall be followed.</p>	F 502		

**Physical Restraint Re-Assessment**

1. Reason for restraint (medical condition/symptom): \_\_\_\_\_  
\_\_\_\_\_
2. Type of restraint: \_\_\_\_\_  
\_\_\_\_\_
3. Periods of day/night used: \_\_\_\_\_  
\_\_\_\_\_
4. Resident location during periods of use: \_\_\_\_\_  
\_\_\_\_\_
5. Resident response to restraint: \_\_\_\_\_  
\_\_\_\_\_
6. Is physical functioning enhanced by restraint use? (explain) \_\_\_\_\_  
\_\_\_\_\_
7. Is physical functioning diminished by restraint use? (explain) \_\_\_\_\_  
\_\_\_\_\_
8. Is resident involved in restorative nursing program? (identify) \_\_\_\_\_  
\_\_\_\_\_
9. List all less restrictive alternatives attempted PRIOR to initiation of physical restraint:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Resident response to alternatives: (explain) \_\_\_\_\_  
\_\_\_\_\_

10. When were less restrictive alternatives last attempted? \_\_\_\_\_

**QA Evaluation:**

11. Physician order identifies:
 

Medical condition/symptom warranting use of restraint:	(Yes)	(No)
Type of restraint:	(Yes)	(No)
When to use restraint:	(Yes)	(No)
Release schedule:	(Yes)	(No)
12. Physical Restraint RAP completed or reviewed? (Yes) (No)
 

Addresses risk/benefit of use?	(Yes)	(No)
Reviewed quarterly?	(Yes)	(No)
Revised as needed?	(Yes)	(No)
13. Interdisciplinary Care Plan identifies:
 

Nursing measures?	(Yes)	(No)
Monitoring of effectiveness?	(Yes)	(No)
Monitoring of physical functioning?	(Yes)	(No)
Monitoring of psychosocial effects?	(Yes)	(No)
Reviewed/revised at least quarterly?	(Yes)	(No)

\_\_\_\_\_  
Resident Name
Room #
Physician

**NIM HENSON GERIATRIC CENTER**

**RESTRAINT PROGRAM**

**Policy:** Nim Henson Geriatric Center supports the belief that our residents will be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical condition. The use of a physical restraint requires a assessment, physician's order and written informed consent of the resident's family or legal representative.

Restraints may be used for emergency care for brief periods to permit medical treatment to proceed unless the facility has a notice indicating that the resident has previously made a valid refusal of the treatment in question. If a resident's unanticipated violent or aggressive behavior places him/her or others in imminent danger, the resident may be restrained as a last resort to protect the safety of the residents or others. This restraint must not extend past the immediate episode.

**Purpose:**

To provide each resident of Nim Henson Geriatric Center with the opportunity to reach his/her highest practicable well-being and the highest possible quality of care by permitting them to take the "normal risk of everyday life".

**POLICY:** Restraints will be used

1. As a last resort measure after a trial period where alternative, less restrictive measures have been undertaken and proven unsuccessful.
2. With a physician's order. The physician is involved in determination of medical condition/symptoms that may warrant the use of restraint and is included in the assessment/decision making process. A physician/s order will include:

- a. Type of restraint
  - b. Specific medical symptom requiring the restraint
  - c. When the restraint is to be used
  - d. Visual checks every 30 minutes and release every 2 hours for routine care
3. With the informed consent of the resident or legal representative. In an emergency, the nurse shall obtain verbal consent from the resident and /or legal representative and record this consent in the resident's record. Social Services will be notified to obtain informed consent for the use of the restraint on the next business day. In the event that the legal representative cannot make a visit to the facility to give written consent, the form may be faxed or mailed to the appropriate location for a signature. The resident and/or legal representative will provide authorization by signing the informed consent for the use of physical restraint.
4. When the benefits of the restraints outweigh the identified risks, and a assessment has been completed. Alternate, less restrictive interventions that may be incorporated into the plan of care include, but not limited to :
- a. Restorative nursing care to enhance ability to stand safely and or walk with out assistance.
  - b. An over bed trapeze to increase bed mobility.
  - c. Positioning the bed lower to the floor, use of mats
  - d. use of alarm device that monitors attempts to rise
  - e. Scheduled toileting program to assist residents to toilet on a routine schedule
  - f. Pain management program
  - g. Frequent staff monitoring while the resident is unattended
  - h. Use of visual and or verbal reminders to use the call bell for residents who are able to comprehend and retain this information
  - I. Use of mattress with elevated perimeters
  - j. Use of alternative seating to maximize position and control

5. Resident's who are restrained will be monitored at least every 30 minutes. Restraints are to be removed at least every 2 hours for 10 minutes. At this time the resident is toileted, repositioned, ambulated or passively exercised as is appropriate for him/her.
6. Notification of the DON/Supervisor/SSW for new restraints shall be noted with the communication form.

**NIM HENSON GERIATRIC CENTER  
RESTRAINT COMMITTEE**

**POLICY STATEMENT:**

To assure compliance with Nim Henson Geriatric Center's Restraint Program Policy and Procedures.

The following disciplines will be represented on the committee.

\*Nursing                      \*Activities                      \*Administrator

\*Social Services              \* Physical Therapy(prn)

\* MDS Coordinators

**PROCEDURE:**

1. The Restraint Committee will meet monthly with QA to assess residents regarding their need for and type of restraint use. All residents who are using restraints will be assessed according to MDS assessment schedules, and the MDS Coordinators will be responsible for corresponding dates.

### Restraint Use Assessment Form

1. What is the specific medical symptom or clinical problem that the use of restraints will address?

\_\_\_\_\_

2. What is the clinical outcome or end point desired?

\_\_\_\_\_

3. What alternative measures have been attempted?

\_\_\_\_\_

4. Is there a physician's order listing type, reason and when restraint is to be used?

5. Has the resident or responsible party consented to restraint use and been informed of potential risks and benefits of use, alternatives to use and how the use of restraints will treat the medical symptom and assist the resident in attaining his/her highest practicable level of physical or psychological well-being?

6. Is the least restrictive restraint being used for the least amount of time? List restraint and explain.

\_\_\_\_\_

7. Do the benefits outweigh the risk of restraint use for this resident?

8. This resident does \_\_\_\_\_ does not \_\_\_\_\_ qualify for restraint use.

Nurse : \_\_\_\_\_ Date \_\_\_\_\_

Resident: \_\_\_\_\_

### PHYSICAL RESTRAINTS

**DEFINITION:** A physical restraint is any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

The following benefits/risks of \_\_\_\_\_ restraints have been discussed with \_\_\_\_\_ (resident), and/or \_\_\_\_\_ (surrogate/decision maker).

Reason for use: \_\_\_\_\_

How restraint would treat medical symptom: \_\_\_\_\_

How restraint would assist the resident in attaining/maintaining his/her highest practicable level of physical or psychological well-being: \_\_\_\_\_

#### POTENTIAL BENEFITS:

- 1. Enable bed mobility
- 2. Enable independent wheelchair mobility
- 3. Enable better sitting balance, positioning or mobility
- 4. Enable to sit still long enough to feed self
- 5. Treat life threatening problems: Dehydration, electrolyte imbalance, urinary blockage, re-fracture, and severe violence to self or others.
- 6. Prevent removal of tube or treatment:
  - a. Catheter
  - b. IVs
  - c. Oxygen mask/cannula
  - d. Nasogastric tube
  - e. Gastrostomytube
  - f. Dressings
- 7. Other: \_\_\_\_\_
- 8. Enable/Assist with transfer in/out of bed.
- 9. Enable resident to feel secure by setting bed parameter

#### POTENTIAL RISKS:

- 1. Decline in resident's physical functioning and muscle condition.
- 2. Contractures, loss of bone mass, fractures
- 3. Increased incidence of infections
- 4. Increased risk for development of pressure sores
- 5. Delirium
- 6. Agitation
- 7. Incontinence
- 8. Increased risk for falls or head trauma, strangulation, entrapment
- 9. Loss of autonomy, dignity, and self respect
- 10. Withdrawal, depression, reduced social contact
- 11. Other: \_\_\_\_\_
- 12. Skin tears bruises
- 13. Climbing over rails

I understand that I have the right to refuse use of a physical restraint/bed rail, and I have been fully informed of the above risks and benefits related to usage and the consequences of the non-use of restraints/bed rails. After careful consideration of the information provided to me, I hereby (initial one):

\_\_\_\_\_ Give my consent for the use of restraint(s)/bed rails  
\_\_\_\_\_ Refuse to give my consent for the use of restraints/bed rails

Date \_\_\_\_\_ Resident \_\_\_\_\_  
Date \_\_\_\_\_ Surrogate Decision Maker \_\_\_\_\_  
Date \_\_\_\_\_ Nurse \_\_\_\_\_

RESIDENT'S NAME: \_\_\_\_\_ PHYSICIAN: \_\_\_\_\_

Restraint Committee Meeting / Elopement and alarm meeting

Date:

Attendance roster

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New restraint orders

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List residents who continue to use a restraint.

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After review are any D/C or reductions to be made>

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# RESTRAINT CARE FLOW SHEET

Restraint Code: \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

ROOM \_\_\_\_\_

PATIENT \_\_\_\_\_

DATE →	11-7	7-3	3-11	11-7	7-3	3-11	11-7	7-3	3-11	11-7	7-3	3-11	11-7	7-3	3-11
RESTRAINTS CK q 30 MINS. RELEASE q 2 HRS. FOR 10 MINS. EXERCISE & TURN															
1st 2 hr. PERIOD															
2nd 2 hr. PERIOD															
3rd 2 hr. PERIOD															
4th 2 hr. PERIOD															

DATE →	11-7	7-3	3-11	11-7	7-3	3-11	11-7	7-3	3-11	11-7	7-3	3-11	11-7	7-3	3-11
RESTRAINTS CK q 30 MINS. RELEASE q 2 HRS. FOR 10 MINS. EXERCISE & TURN															
1st 2 hr. PERIOD															
2nd 2 hr. PERIOD															
3rd 2 hr. PERIOD															
4th 2 hr. PERIOD															

DATE →	11-7	7-3	3-11	11-7	7-3	3-11	11-7	7-3	3-11	11-7	7-3	3-11	11-7	7-3	3-11
RESTRAINTS CK q 30 MINS. RELEASE q 2 HRS. FOR 10 MINS. EXERCISE & TURN															
1st 2 hr. PERIOD															
2nd 2 hr. PERIOD															
3rd 2 hr. PERIOD															
4th 2 hr. PERIOD															

### Physical Restraint Re-Assessment

1. Reason for restraint (medical condition/symptom): \_\_\_\_\_  
\_\_\_\_\_
2. Type of restraint: \_\_\_\_\_  
\_\_\_\_\_
3. Periods of day/night used: \_\_\_\_\_  
\_\_\_\_\_
4. Resident location during periods of use: \_\_\_\_\_  
\_\_\_\_\_
5. Resident response to restraint: \_\_\_\_\_  
\_\_\_\_\_
6. Is physical functioning enhanced by restraint use? (explain) \_\_\_\_\_  
\_\_\_\_\_
7. Is physical functioning diminished by restraint use? (explain) \_\_\_\_\_  
\_\_\_\_\_
8. Is resident involved in restorative nursing program? (identify) \_\_\_\_\_  
\_\_\_\_\_
9. List all less restrictive alternatives attempted PRIOR to initiation of physical restraint:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Resident response to alternatives: (explain) \_\_\_\_\_  
\_\_\_\_\_
10. When were less restrictive alternatives last attempted? \_\_\_\_\_

**QA Evaluation:**

11. Physician order identifies:
 

Medical condition/symptom warranting use of restraint:	(Yes)	(No)
Type of restraint:	(Yes)	(No)
When to use restraint:	(Yes)	(No)
Release schedule:	(Yes)	(No)
12. Physical Restraint RAP completed or reviewed? (Yes) (No)
 

Addresses risk/benefit of use?	(Yes)	(No)
Reviewed quarterly?	(Yes)	(No)
Revised as needed?	(Yes)	(No)
13. Interdisciplinary Care Plan identifies:
 

Nursing measures?	(Yes)	(No)
Monitoring of effectiveness?	(Yes)	(No)
Monitoring of physical functioning?	(Yes)	(No)
Monitoring of psychosocial effects?	(Yes)	(No)
Reviewed/revised at least quarterly?	(Yes)	(No)

Resident Name	Room #	Physician
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QUARTERLY PHYSICAL RESTRAINT ELIMINATION ASSESSMENT

1-2-1

1. Candidate for restraint reduction or elimination program? Yes No

If YES, Date program to start / /

Plan of action:

Less restrictive measure to be used:

If NO, state specific reason or targeted behavior:

2. Additional comments:

Nurse's signature: Date:

1. Candidate for restraint reduction or elimination program? Yes No

If YES, Date program to start / /

Plan of action:

Less restrictive measure to be used:

If NO, state specific reason or targeted behavior:

2. Additional comments:

Nurse's signature: Date:

1. Candidate for restraint reduction or elimination program? Yes No

If YES, Date program to start / /

Plan of action:

Less restrictive measure to be used:

If NO, state specific reason or targeted behavior:

2. Additional comments:

Nurse's signature: Date:

1. Candidate for restraint reduction or elimination program? Yes No

If YES, Date program to start / /

Plan of action:

Less restrictive measure to be used:

If NO, state specific reason or targeted behavior:

2. Additional comments:

Nurse's signature: Date:

F 431  
F 425

**MONTHLY MEICATION CART/LAB  
SUPPLIES AUDIT**

**OUTDATED MEDS**

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**MEDS REORDERED**

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**LAB SUPPLIES OUTDATED/REORDERED**

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**IV CARD AUDIT**

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**NURSE'S SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**TEAM:** \_\_\_\_\_

**TO BE DONE BY NIGHT SHIFT NURSE THE FIRST  
AND THIRD WEEKEND OF THE MONTH AND  
TURNED IN TO SUPERVISOR**

## DENTURE PROTOCOL

Copy of dental assessment completed will be given to SSD for all resident's admitted with dentures.

For residents with dentures:

At bedtime the CNA will assist with removal or ensure removal of dentures and placement in denture cup.

When getting resident's up in the morning CNA will assist or ensure the removal of dentures and place in the denture cup. (If resident is alert and oriented and requests to sleep in their dentures they are to be permitted to do so)

When getting resident up in the morning CNA will assist or ensure that residents dentures are placed in their mouths.

When discarding trays staff will verify that dentures are not wrapped in napkins on tray.

When dentures are missing:

1. The residents' room will be thoroughly searched.
2. CNA will report to nurse.
3. Nurse will report to the Social Worker via communication form
4. Social Worker will notify family of the missing dentures.
5. Social Worker will schedule a dental appointment for resident as soon as possible (transportation considerations).
6. Social Worker will notify nurse of appointment so transportation arrangements can be made.
7. Social Worker will conduct interviews to attempt to ascertain what occurred with the dentures.
8. Resident/and or family will be notified of cost to identify payment source by social worker.



NIM HENSON GERIATRIC CENTER

LABORATORY POLICY

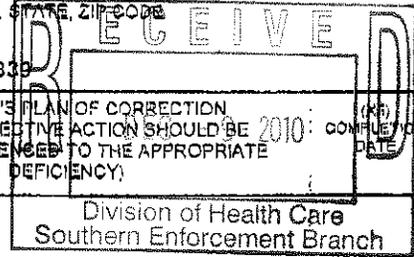
1. OBTAIN ORDER FROM MD
2. IMMEDIATELY PLACE ON THE LABORATORY BOOK AS WELL AS THE LAB CARD THE DATE DUE
3. FORWARD THE ORDER ONTO THE APPROPRIATE PERSONEL(DON, SUPERVISOR OR DESIGNEE) FOR NOTIFICATION
4. THE DON, SUPERVISOR OR DESIGNEE WILL COMPLETE A 10% AUDIT MONTHLY OF LAB ORDERS
5. AT THE END OF THE MONTH THE DAY SHIFT NURSE WILL PLACE THE LABS ON THE CALENDAR FOR THE NEXT MONTH AND FORWARDED A LIST ON TO THE DON/ SUPERVISOR
6. ROUTINE LABARATORY DATES MAY BE ADJUSTED PRN TO DECREASE AMOUNT OF BLOOD DRAWS TO PATIENTS

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NAME OF PROVIDER OR SUPPLIER  NIM HENSON GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339
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K 000	INITIAL COMMENTS  A life safety code survey was initiated and concluded on November 9, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.  Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. The facility failed to ensure that penetrations above fire/smoke barrier doors were properly sealed. This deficient practice affected four (4) of six (6) smoke compartments, staff, and approximately fifty (50) residents. The facility has the capacity for 120 beds with a census of 81 on the day of the survey.	K 025 K025	No individual resident was identified as being affected by this practice. Team III duct work thru firewall will be replaced by 12/22/10. Team I firewall will be sealed by 12/22/10.  Any resident could be affected if NFPA 101 Life Safety Code Standard is not adhered to.  Maintenance Supervisor inserviced on performing prompt maintenance to any areas pertaining to NFPA Life Safety Code Standard on 12/03/10. Maintenance Supervisor will monitor building during routine maintenance for any smoke barrier problems.  The Administrator/Designee will monitor the building quarterly for compliance. The QA Committee will be asked for solutions to any persistent problem.  Completion Date:	12/22/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Phillip A. Littoral* TITLE: *Administrator* (X6) DATE: *12-9-10*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Received Time Dec. 9. 2010 5:32PM No. 4821

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NAME OF PROVIDER OR SUPPLIER  NIM HENSON GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339
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K 025	<p>Continued From page 1</p> <p>The findings include:</p> <p>During the Life Safety Code survey on November 9, 2010, at 12:00 p.m., with the Director of Maintenance (DOM), unsealed ductwork was observed penetrating the fire/smoke barrier wall above the Team III cross-corridor doors. Fire/smoke barrier walls must be properly maintained to prevent fire and smoke from spreading to other areas of the facility. During the survey two unsealed copper lines were observed penetrating the fire/smoke barrier wall above the cross-corridor doors at the Team I workstation.</p> <p>An interview with the DOM on November 9, 2010, at 12:00 p.m., revealed the DOM was not aware these penetrations should be properly sealed.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration</p>	K 025		
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K 025	Continued From page 2 into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	<i>No resident was identified as being directly affected by the practice. Paint was removed from sprinkler heads in kitchen mop room, Team III nurses station and in hall next to room 105 on 11/12/10. The corroded heads were cleaned on 11/12/10. Lint was removed from sprinkler head in laundry on 11/10/10.</i>		
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinkler heads were maintained as required. This deficient practice affected three (3) of six (6) smoke compartments, staff, and approximately forty-five (45) residents. The facility has the capacity for 120 beds with a census of 81 on the day of the survey.  The findings include:  During the Life Safety Code survey on November 9, 2010, at 10:00 a.m., with the Director of Maintenance (DOM), corrosion was noted on the sprinkler head in the kitchen dish room and paint on the sprinkler head in the kitchen mop room. Not maintaining sprinkler heads can decrease their ability to react as intended. An interview with the DOM on November 9, 2010, at 10:00 a.m., revealed the DOM was not aware sprinkler heads should be maintained. During the survey paint was noted on sprinkler heads at the Team III nursing station and in the corridor next to room 105. A corroded sprinkler head was observed at the front entrance of the facility. Lint was		<i>Any resident could be affected by sprinkler heads that do not work properly; however, no specific resident was identified. All sprinkler heads were checked for compliance on 11/12/10 by maintenance. No other problems found. Landmark Sprinkler will do a complete assessment of sprinkler heads during the quarterly inspection on 1/3/11. Sprinkler heads will be replaced where necessary.  Maintenance Supervisor was inserviced on properly maintaining all sprinkler heads at all times on 11/12/10. Landmark Sprinkler will be instructed to visually check all heads during quarterly inspections on 01/03/11 and to replace any that need to be. Housekeeping and Laundry will be inserviced on keeping sprinkler heads clean on 12/13 &amp; 12/15/10.  Housekeeping, Laundry, and Maintenance Supervisors will do daily monitoring of sprinkler heads for cleanliness and corrosion. Administrator Designee will do quarterly monitoring. Persistent problems will be presented to QA Committee for solution.  Completion Date: 12/22/10</i>		

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K 062	Continued From page 3 observed to be built up on the sprinkler heads in the laundry area. The facility was cited on November 3, 2009, for paint on sprinkler heads  Reference: NFPA 25 (1998 Edition).  2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure a weekly written maintenance schedule was being performed on the emergency generator. This deficient practice affected six (6) of six (6) smoke compartments, staff, and eighty-one (81) residents. The facility has the capacity for 120 beds with a census of 81 on the day of the survey.  The findings include:	K 144	K144  <i>No resident was identified as being affected by the generator inspection schedule.</i>  <i>Any resident could be affected by lack of inspections according to K144 regulations.</i>  <i>Maintenance Supervisor was inserviced on 12/3/10 on performing generator inspections weekly as outlined in K144.</i>  <i>Administrator/Designee will monitor inspection reports monthly for 3 months and then quarterly if compliance is met. The QA Committee will be advised of any compliance problems.</i>  <i>Completion Date:</i>	12/03/10

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K 144	Continued From page 4  During the life safety code tour on November 9, 2010, at 12:30 p.m. with the Director of Maintenance (DOM), a record review revealed the generator maintenance schedule was being performed approximately three times a month instead of weekly as required. An interview with the DOM on November 9, 2010, at 12:30 p.m., revealed the DOM was not aware of the weekly maintenance schedule requirement. The facility was cited on November 3, 2009, for the same deficient practice.  Reference: NFPA 110 (1999 Edition).  6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction  6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established  6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.  6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the	K 144		

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K 144	Continued From page 5, standard position.	K 144		
K 147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical power strips were being used in an approved manner. This deficient practice affected one (1) of six (6) smoke compartments, staff, and approximately four (4) residents. The facility has the capacity for 120 beds with a census of 81 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on November 9, 2010, at 11:30 a.m., with the Director of Maintenance (DOM), an electric bed, oxygen concentrator, nebulizer, and trachea equipment were observed to be plugged into a multi-outlet adapter (power strip) in resident room 103. In addition, power strips were observed to be in use with medical equipment in resident rooms 105 and 109. Generally, multiple-outlet adapters with surge protection may be used for resident TVs, computers, radios, etc., on an as-needed basis but not to be used with medical equipment to help prevent against electrical shock.</p> <p>An interview with the DOM on November 9, 2010, at 11:30 a.m., revealed the DOM was not aware of the proper use of multiple- outlet adapters.</p>	K 147	<p><i>K147</i></p> <p><i>The power strips in room 103, 105, and 109 have been removed. Sufficient receptacles have been installed in room 103, 105, and 109.</i></p> <p><i>Any resident could be affected by the use of power cords. All rooms were checked and no other receptacle problems were found.</i></p> <p><i>Staff will be inserviced on 12/13 &amp; 12/15/10 the importance of proper use of power cords. The need for additional outlets will be reported to the maintenance supervisor immediately by nursing and/or housekeeping. He will install additional receptacles as needed.</i></p> <p><i>Housekeeping supervisor will monitor rooms daily for the use of power cords. Maintenance worker will monitor during routine maintenance. Administrator/Designee will monitor during daily observations and during quarterly inspections. QA committee will be notified of ongoing problems.</i></p> <p><i>Completion Date:</i></p>	12/03/10

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K 147	Continued From page 6 The Director of Maintenance stated that sometimes there were not enough receptacles in resident rooms.  Reference: NFPA 99, (1999 Edition),  3-3.2.1.2 D 2. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147			

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F 279	<p>Continued From page 6 comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to develop a comprehensive care plan for two (2) of eighteen (18) sampled residents. Residents #1 and #3 required the use of an anticoagulant/blood thinner; however, a care plan was not developed to address the anticoagulants and necessary precautions. Additionally, resident #1 had a peripherally inserted central catheter (PICC) line and the facility failed to develop a care plan related to the care/precautions and possible complications related to a central intravenous line.</p> <p>The findings include:</p>	F 279	<p>F279,</p> <p><i>The Care Plans for the affected residents (#1 and #3) have been revised to reflect that the current deficiencies have been addressed.</i></p> <p><i>An audit has been completed per nursing staff to manage residents on anticoagulant therapy. Care Plans were updated for residents identified as result of audit.</i></p> <p><i>A Care Plan checklist was put into effect as of 11/10/10 and is done prior to completion of each Care Plan made. The checklist will be kept in the MDS office with the resident's file. Also, the nursing staff is now required to provide a copy of all new orders to MDS to facilitate in Care Plan updates.</i></p> <p><i>All residents will receive quarterly reviews to ensure all needs are being met and Care Plans are updated to show current status.</i></p> <p><i>M.D.S. Coordinator and staff will be inserviced on checklist and care plan updates.</i></p> <p><i>D.O.N./Designee will complete a quarterly audit of check list with care plans for compliance. Q.A. Committee will be asked for input on continued problems.</i></p> <p><i>Completion Date: 12/15/10</i></p>	

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F 411	Continued From page 14 Resident #11 stated that at night the denture was taken out to be cleaned; and then placed in a cup for the night. Resident #11 further stated one morning the cup that contained the resident's upper denture was missing. Resident #11 stated the incident took place a few months ago, however, was not certain of the exact month. Interview further revealed the resident had informed staff that the denture was missing. According to the resident it was hard to eat some meals due to the loss of the upper denture and he/she would like to have the denture replaced.	F 411		
F 425 SS=D	Interview on November 10, 2010, at 11:23 a.m., with the Social Services Director (SSD) revealed the SSD was aware resident #11's upper denture was missing. The SSD stated that staff had looked for the denture and was unable to find the denture.  Interview on November 10, 2010, at 1:30 p.m., revealed the SSD had "not thought about [resident #11's] teeth lately," and no further effort had been made to locate or replace the missing denture. Interview further revealed the denture was lost approximately in June 2010, and the SSD had not obtained a dental appointment since the loss of the denture.  483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	F425,  The expired medication for resident #18 was removed and M.D. and Pharmacy were notified.  The medication cart was then audited that day for any further expired medications and none were found. The Pharmacy also completed a monthly audit of all medication carts on 11/16/10.  To ensure that this deficit practice does not re-occur the night shift nurse will complete a bi-monthly cart audit. The medication carts will be checked for expired medication and any found will be removed. M.D. and Pharmacy will then be notified. All nursing staff will be inserviced on 12/13 & 12/15/10 as to insure compliance.  To ensure that the solutions are sustained, the Pharmacy will continue their monthly audits, and night shift nurses will continue bi-monthly audits. Q.A. committee will address any problems.  Completion Date: 12/15/10	

## CAREPLAN CHECKLIST

\_\_\_ *DIAGNOSES: EX. (DM, COPD, CHF, SEIZURE DIS)*

\_\_\_ *MEDS: EX. (ANTI-COAGULANTS, ANTI-PSYCHOTICS, DIURETICS,  
ANTI-DEPRESSANTS, ANTI-CONVULSANTS, SEDATIVES,  
ANTIBIOTICS, ANTI-HYPERTENSIVES)*

\_\_\_ *MOOD AND BEHAVIORS?*

\_\_\_ *DELIRIUM? HALLUCINATIONS OR DELUSIONS?*

\_\_\_ *ADL FUNCTION?*

\_\_\_ *INCONTINENCE?*

\_\_\_ *ACTIVITIES?*

\_\_\_ *COMMUNICATION PROBLEM?*

\_\_\_ *RISK FOR SKIN BREAKDOWN? CURRENT ULCER TX?*

\_\_\_ *RISK FOR FALLS?*

\_\_\_ *PAIN?*

\_\_\_ *COGNITIVE LOSS?*

\_\_\_ *POTENTIAL FOR OR HX OF UTI? CATHETER PRESENT?*

\_\_\_ *IV OR CENTRAL LINE?*

\_\_\_ *VISION OR HEARING IMPAIRMENT?*

\_\_\_ *NUTRITION? DENTAL PROBLEMS?*

\_\_\_ *FEEDING TUBE?*

\_\_\_ *DEHYDRATION AND FLUID MAINTENANCE?*

\_\_\_ *RESTRAINTS?*

\_\_\_ *DNR?*